



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8 0 2 6 0 1 5

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Charles		MIDDLE T.		LAST Burns Sr.		2b. DATE KNOWN OF DEATH ESTI- MATED		MONTH 10		DAY 28		YEAR 1980		2b. HOUR 14	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH April		DAY 2		YEAR 1903		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MINS.		IF UNDER 24 HRS. HOURS MINS.		2c. DATE PRONOUNCED DEAD	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.											
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4400 Bartholow Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter		12b. KIND OF BUSINESS OR INDUSTRY Home											
13a. STATE Md.		13b. COUNTY CARROLL		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4400 Bartholow Rd.									
14. FATHER'S NAME FIRST DARIUS		MIDDLE W.		LAST BURNS		15. MOTHER'S MAIDEN NAME FIRST Campsidel		MIDDLE Haines		LAST Haines							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT Eva Burns		ADDRESS Sykesville, Md.											
18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hrs																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?															
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held in death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion TITLE (SPECIFY) MEDICAL EXAMINER DATE SIGNED 28 Oct 80																	
ACTUAL SIGNATURE Richard A. Doros MD		ADDRESS CARROLL COUNTY GENERAL HOSP															
EXAMINER'S NAME (TYPE OR PRINT)																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-1-80		23c. NAME OF CEMETERY OR CREMATORY Greenwood Chapel Cemetery		23d. LOCATION CITY OR TOWN Woodbury		COUNTY Howard		STATE Md.							
24. FUNERAL DIRECTOR NAME Harry W. Haight		ADDRESS Sykesville, Md.		25a. DATE REC'D. BY REGISTRAR NOV 3 1980		25b. REGISTRAR'S SIGNATURE R. H. Haight											

RECEIVED BY THE U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C. 20250



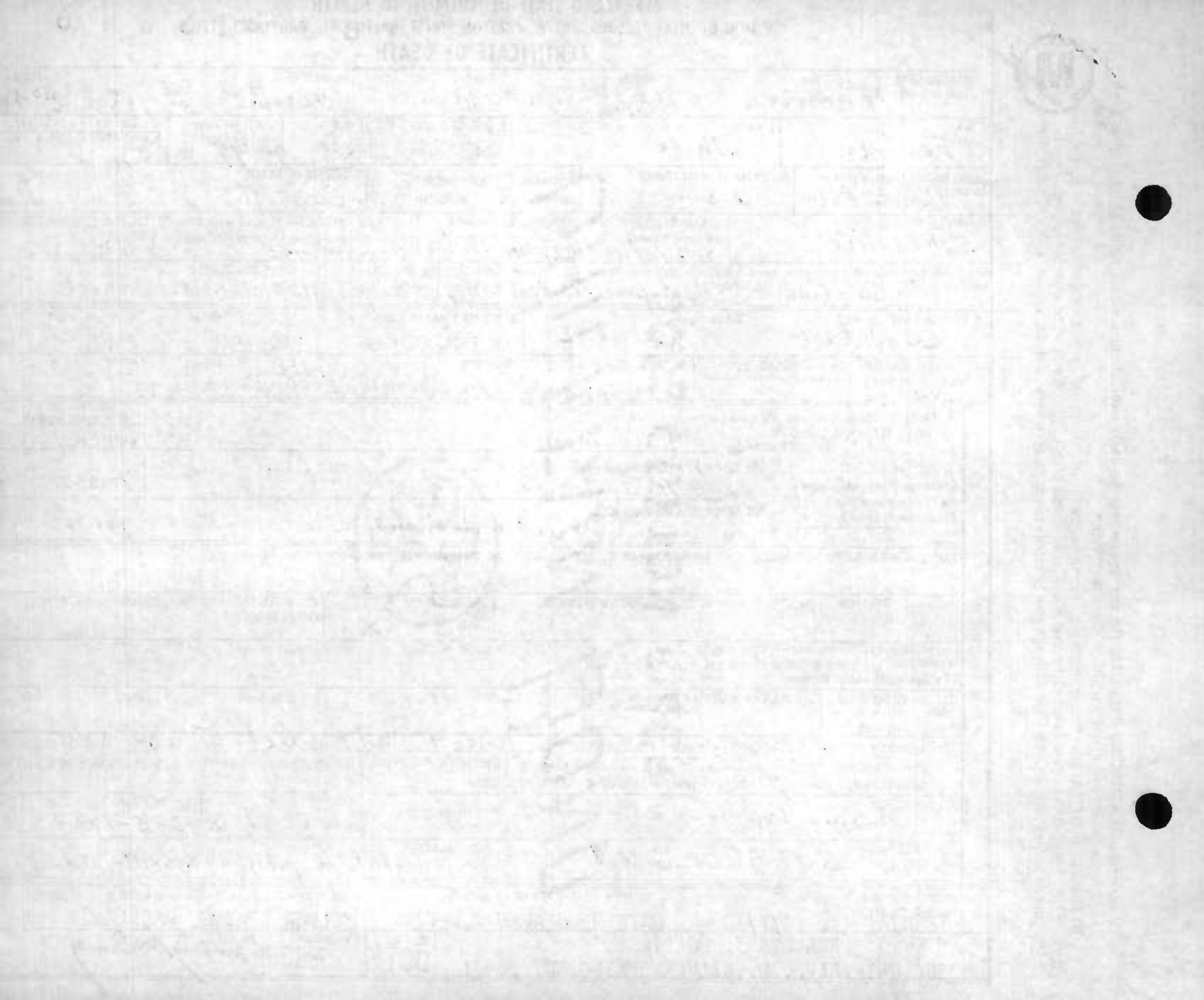
CHIEF OF BUREAU
FOR COTTON



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21206 0 1 6
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Frances G. XXXXXX Capogrosso			2a. DATE OF DEATH Month October Day 5 Year 1980			2b. HOUR 2:10 A.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH 7/6/1904 XXXXXX XXXXXX		6. AGE (In years last birthday) 76 XXX YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Puerto Rico		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll				
10. CITY OR TOWN OF DEATH Sykesville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield Hospital Center			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) unemployed			12b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 11001 Oakwood Street	
14. FATHER'S NAME First Candelario Middle Gonzalez Last Gonzalez			15. MOTHER'S MAIDEN NAME First NARCISA Middle CRUZ Last CRUZ							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 117-09-7929		17. INFORMANT MICHAEL GONZALEZ Address NEPHEW XXXXXXXXXXXXXXXXXXXX SAME AS 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4292 DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V.D. DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis Approximate interval between onset and death: weeks Years years,										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS CONTRIBUTING <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (X) (this hospital) attended the deceased from Jan. 4 , 19 74 , to Oct. 5 , 19 80 , that (I) (we) last saw the deceased alive on Oct. 5 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Suha Ozgun, M.D.						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-5-1980		
22d. PHYSICIAN'S NAME (Type) SUHA OZGUN						22e. ADDRESS Springfield Hospital, Sykesville, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 10/7/80		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY			23d. LOCATION (City or Town) (County) (State) SILVER SPRING, MARYLAND		
24. FUNERAL DIRECTOR FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901						25a. REC'D BY REGISTRAR OCT 7 1980		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, on any event, within 72 hours after death.





STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

26017

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH		DAY		YEAR		20. HOUR	
ANNA						D. GIOVANNI		10 29 1980								4 18 PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		21. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
female	white	3 21 1908		72						10 29 1980						4 18 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
MD		USA		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Carroll County											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Westminster		Carroll County General Hospital		Homemaker													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
MD		Carroll		Westminster		YES <input type="checkbox"/> NO <input type="checkbox"/>		920 Winchester Drive									
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST							
Michael				Rotunno		Raphaela				Dantoni							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		215-12-3046		Mrs. Grace Buett		21157											
				920 Winchester Drive, Westminster, MD													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
4292		Atherosclerotic Cardiovascular Disease				Yes											
		(b)		DUE TO, OR AS A CONSEQUENCE OF													
		(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input checked="" type="checkbox"/>		and in my opinion									
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Richard A. Jones		Carroll County General Hosp. Westminster, MD															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
Burial		11/3/80		Holy Redeemer Cemetery		Baltimore City		MD									
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Loring Byers, Funeral Directors, P.A.		OCT 31 1980		[Signature]													
8728 Liberty Rd., Randallstown, MD 21133																	

BP

DHMH - 17
(VR A15 ME(5))
15M 7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

THIRD CLASS - CO. 10th IN DEPT.
WHEATON, ILL. 60187
THIRD CLASS - CO. 10th IN DEPT.



2029

DEC 11 1903



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VIR A15 ME (5))
15M 7/76

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH		2b. HOUR	
EULALIA L. FRANCIS		10 29, 80		M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.
female	white	5 11 24	56	MONTHS	DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Maryland		USA		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Manchester		3223 Tracey Mill Rd.		Hwf	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Carroll		Manchester	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	
Edward		Annie		no	
16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
219-14-5790		Mr. Charles Francis, Manchester, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a): Cerebral hemorrhage					
DUE TO, OR AS A CONSEQUENCE OF					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Ann M. Dixon, M.D.		Assistant		10-30-80	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
		111 Penn St.			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		10-29-80		Immanuel Cemetery	
23d. LOCATION		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
Manchester Carroll Md.		NOV 6 1980		History McQuinn	
24. FUNERAL DIRECTOR		25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Eline Funeral Home, Hampstead, Md.					



70

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.83
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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 2 6 0 1 9					
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH				REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				MONTH		YEAR		2b. HOUR			
John RATION GRAHAM JR				OCT 3 1980				04		46		M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS					
MALE		WHITE		MONTH DAY YEAR SEPT 27 1927		53 YRS.		MONTHS DAYS		HOURS MIN					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						MD.			
VA.		U.S.A.				CARROLL									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Westminster		104 Liberty STREET				OWNER		SERVICE Station							
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Md				CARROLL		Westminster		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		104 Liberty					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
John R. GRAHAM SR				Bertha A. Anderson											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
YES				KOREAN		218 32 9068		F. Virginia Westminster, Md							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a):										RES. FAIL.					
1629										DUE TO, OR AS A CONSEQUENCE OF		7 MOS			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:										(b):		LONG CANCER			
										(c):		DUE TO, OR AS A CONSEQUENCE OF			
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		HOUR A.M. MONTH DAY YEAR													
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		CITY OR TOWN		COUNTY		STATE					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET											
22a. I certify that (I) this hospital attended the deceased from 1980 to OCT 2 1980, that (I) (we) last saw the deceased alive on OCT 2 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
										M. Susan Bollinger MD				10/3/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS											
M. SUSAN BOLLINGER				215 W. 11th St. MED CTR. WEST.											
23a. BURIAL, CREMATION, REMOVAL (TYPE)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE			
Burial		10-6-80		EVERGREEN		Finksburg		CARROLL		Md					
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Robert Kyle Pruthi Jr. Westminster, Md.				OCT 8 1980											

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

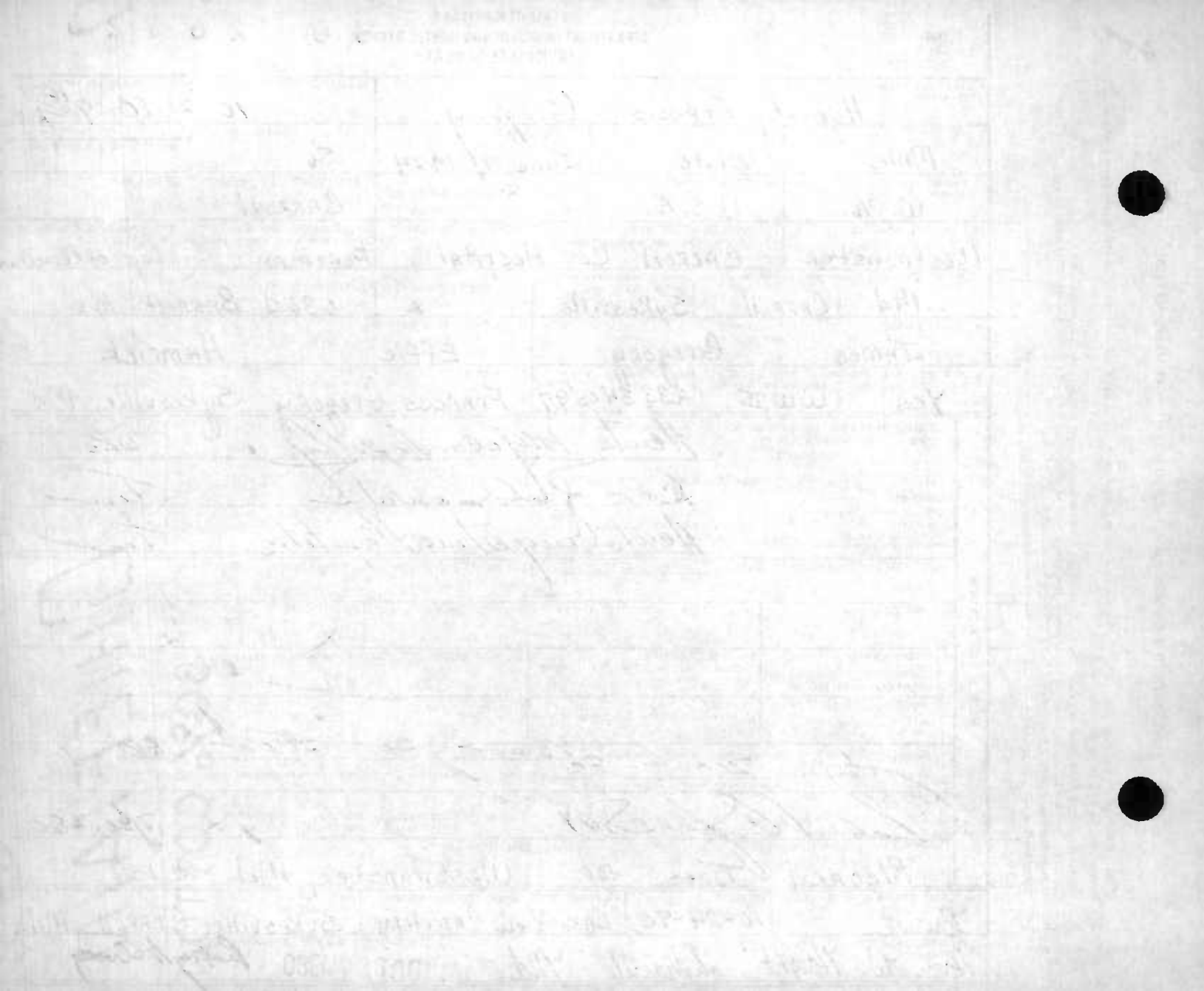
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Hubert Francis Gregory			2a. DATE OF DEATH MONTH DAY YEAR 10 21 80			2b. HOUR 9:15 M	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 9, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.	
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL Co. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman	
13a. STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James Gregory		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Effie Hamrick					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS Frances Gregory Sykesville, Md.			
18. CAUSE OF DEATH Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4254 Acute Myocardopathy. DUE TO, OR AS A CONSEQUENCE OF (b) Cor Pulmonale DUE TO, OR AS A CONSEQUENCE OF (c) Acute Congestive Hepatitis CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Wks Weeks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I (this hospital) attended the deceased from 21 Oct 80 to 21 Oct 80 , that I (we) lost 21 Oct 80 21 Oct 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did not) view the body after death.							
22b. SIGNATURE Richard James		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7 Oct 80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard James		22e. ADDRESS Westminster Md. 21157					
23a. BURIAL, CREMATION, REMOVAL (IF ANY) Burial		23b. DATE 10-24-80		23c. NAME OF CEMETERY OR CREMATORY LAKE View Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll Md.	
24. FUNERAL DIRECTOR NAME Harry W. Haight				ADDRESS Sykesville, Md.		25a. DATE REC'D. BY REGISTRAR OCT 27 1980	
				25b. REGISTRAR'S SIGNATURE Harry Haight			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified (page 1 and 2).

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1. FOR STATE REGISTRAR					REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) Melvin Lavern Groat					2a. DATE OF DEATH MONTH DAY YEAR 10 3 80			2b. HOUR 2014 ^P		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR December 4, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 54		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Westminster		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.				
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b. KIND OF BUSINESS OR INDUSTRY Gould Inc.		
13a. STATE Maryland					13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. STREET ADDRESS Westminster, Md. 3420 Uniontown Rd. 21157	
14. FATHER'S NAME FIRST MIDDLE LAST Clayton Groat					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertie Yingling Groat					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II 220-98-9814		17. INFORMANT Westminster, Md. 21157 Pauline Groat 3420 Uniontown Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21e. LOCATION STREET CITY OR TOWN COUNTY STATE							
21f. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										
22a. I certify that (I) (this hospital) attended the deceased from <u>10/2</u> 19 <u>80</u> , to <u>10/3</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>10/3</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Thomas D. Fletcher</u> DEGREE					22c. ADDRESS 218 Washington Hgts. Westminster, Md. 21157			22d. DATE SIGNED 10/3/80		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Park W. Espenschade W. Jr.					22f. ADDRESS 218 Washington Hgts. Westminster, Md. 21157					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/6/80		23c. NAME OF CEMETERY OR CREMATORY Uniontown Bible Church		23d. LOCATION CITY OR TOWN COUNTY STATE Uniontown Carroll Md.			
24. FUNERAL DIRECTOR NAME Thomas D. Fletcher & Son F.H. 254 East Main St. Westminster, Md. 21157					25a. BY REGISTER		25b. REGISTRAR'S SIGNATURE			

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[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "United States" and "Department" are faintly visible.]

[Faint text at the bottom of the page, likely a footer or signature area. Some words like "Respectfully" and "Very truly yours" are faintly visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
Ralph Richard Groft		Male		White	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. BALTIMORE CITY OR COUNTY OF DEATH	
December 15, 1930		49 YRS.		Carroll County MD.	
8. CITIZEN OF WHAT COUNTRY?		9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		10. CITY OR TOWN OF DEATH	
U.S.A.		Carroll County		Westminster	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Residence 74 Penna Ave		Construction			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Carroll		Westminster	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Clayton		Bertie Yingling		No	
16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.	
214-28-5376		Mrs. Arlene B. Groft 74 Penna Ave		1419 IMMEDIATE CAUSE (a) Cancer of tongue DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
None					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from Oct 15, 1979, to Oct 4, 1980, that (1) (we) lost saw the deceased alive on Oct 3, 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.		22b. SIGNATURE Julius Chapko		22c. DATE SIGNED Oct 6, 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. MEDICAL EXAMINER'S SIGNATURE	
Julius Chapko		85 1/2 W. Green St. Westminster, Md. 21157		M.O. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		10-7-80		Westminster Cemetery	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Thomas D. Fletcher & Son F.H. 254 East Main St Westminster, Md. 21157		OCT 8 1980		[Signature]	

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Woodrow (NMN) HINES			2a. DATE OF DEATH 10 Month 09 Day 80 Year		2b. HOUR 10:55 AM
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH 01-01-23		6. AGE (In years last birthday) 57 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) South Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll County, Md.	
10. CITY OR TOWN OF DEATH Sykesville, Maryland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield Hospital Ctr.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Loading trucks	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. CITY OR TOWN Baltimore	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2233 Brookfield Avenue	
14. FATHER'S NAME First Middle Last Marion Hines			15. MOTHER'S MAIDEN NAME First Middle Last Lillian Brunson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. 248-03-3560		17. INFORMANT Estell Ervin 2540 Francis St. Records - Springfield Hospital Center	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory arrest 486 - DUE TO, OR AS A CONSEQUENCE OF (b) Septic shock (c) Pneumonia					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes hours days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Right-sided hemiplegia, acute					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that it (this hospital) attended the deceased from March 10, 1980 , to October 9, 1980 , that it (we) last saw the deceased alive on October 9, 1980 , and that in our (our) opinion death occurred on the date and hour and from the causes stated above, it (we) (did) not view the body after death.					
22b. SIGNATURE <i>Octavio A. Ruiz MD</i> DEGREE				22c. DATE SIGNED 10-09-80	
22d. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M.D.				22e. ADDRESS Springfield Hospital Center Sykesville, Maryland 21784	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		23b. DATE 10/15/80		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.	
23d. LOCATION (City or Town) (County) (State) Baltimore MD					
24. FUNERAL DIRECTOR ADDRESS Wm. C. March F/H 1101 E. North Ave.				25a. REC'D BY REGISTRAR OCT 14 1980	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATEMENT OF DEATH

Deceased

(Date)

Place

Age

Sex

Color

South Carolina - U.S.A.

Yamhill, Maryland - Springfield Hospital, Springfield, Maryland

Married

Religion

Education

Occupation

288-00-1500 - Records - Springfield Hospital, Springfield, Maryland

Radio-telephone records

Radio-telephone records

XXX

Telephone records

1144-1100 records, 11, 1940

80

October 1, 1940

1144-1100

Deceased, U.S.A.

Springfield Hospital, Springfield, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 0 2 4
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Edna NMN Hogan			2a. DATE OF DEATH Month 10 Day 6 Year 80		2b. HOUR M
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH 1-1-19	
6. AGE (In years last birthday) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Carroll County Md.					
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) none	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. STREET AND NUMBER 2307 Elsinore Avenue	
14. FATHER'S NAME First Middle Last unknown			15. MOTHER'S MAIDEN NAME First Middle Last unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. ?		17. INFORMANT Address Records, Springfield Hospital Center	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS ACUTE MI. 481- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RT BASE PNEUMONIA - CHF. DUE TO, OR AS A CONSEQUENCE OF (c) PSYCHOSIS & EPILEPSY.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES DAYS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9-19-1978 , to 10-6-1980 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10-6-1980 , and that on <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>[Signature]</i>		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-6-80	
22d. PHYSICIAN'S NAME (Type) Naei N. Bayraktar		22e. ADDRESS Sykesville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-15-80		23c. NAME OF CEMETERY OR CREMATORY Sykesville Cemetery	
23d. LOCATION (City or Town) (County) (State) Sykesville Carroll Md.		23e. REC'D BY REGISTRAR OCT 20 1980			
24. FUNERAL DIRECTOR Harry W. Haight		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

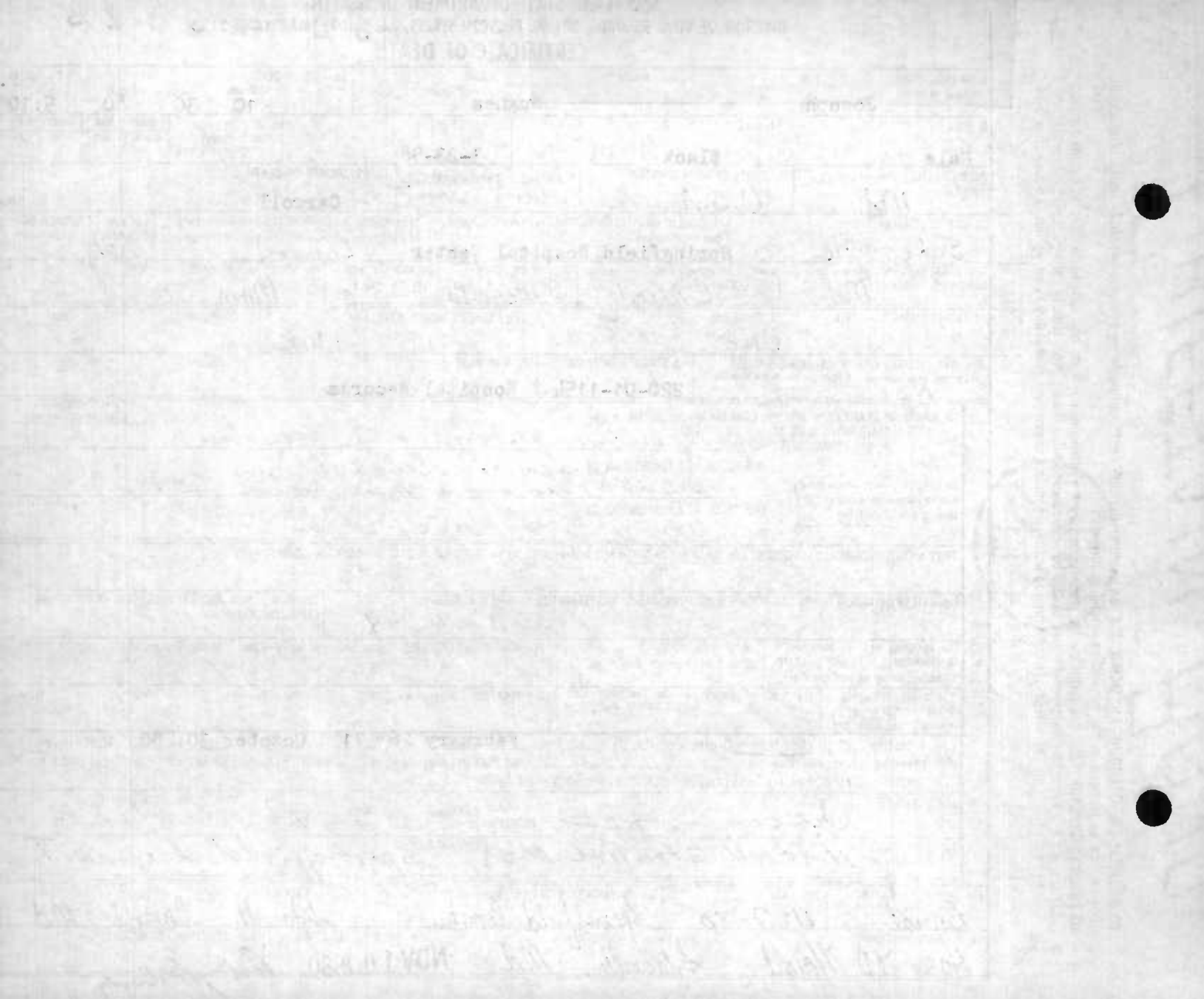
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25m-1/70

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 0 2 5
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Joseph Hughes			2a. DATE OF DEATH Month 10 Day 30 Year 80			2b. HOUR 5:10			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH 3-23-98		6. AGE (In years lost birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll			
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield Hospital Center			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER			12b. KIND OF BUSINESS OR INDUSTRY Bldg.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY CARROLL		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Main St.	
14. FATHER'S NAME First Middle Last Unk			15. MOTHER'S MAIDEN NAME First Middle Last Unk						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 220-01-1154		17. INFORMANT Address Hospital Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia, acute 4292 DUE TO, OR AS A CONSEQUENCE OF gastric dilatation (b) ASCVD, general marasmus, CHF DUE TO, OR AS A CONSEQUENCE OF (c) Unstable disorder (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS CONTRIBUTING <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from February 26 19 71 , to October 30 19 80 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature]				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10/30/80			
22d. PHYSICIAN'S NAME (Type) NACEV Strahil M.D.				22e. ADDRESS Springfield Hosp. Center					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 11-7-80		23c. NAME OF CEMETERY OR CREMATORY Springfield Cemetery		23d. LOCATION (City or Town) (County) (State) Sykesville Carroll Md.			
24. FUNERAL DIRECTOR Harry W. Knight		ADDRESS Sykesville, Md.		25a. REC'D BY REGISTRAR NOV 10 1980		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

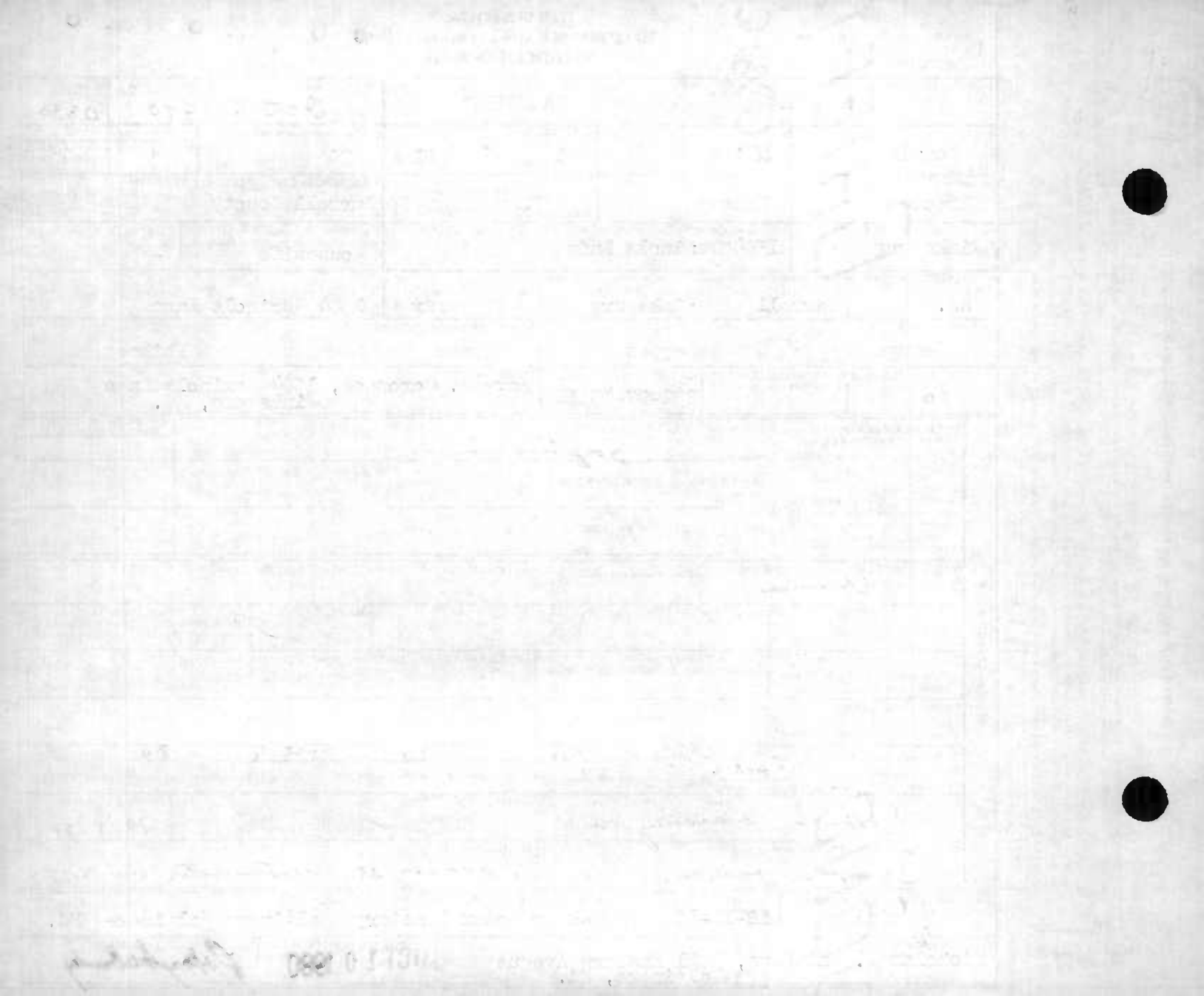
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		2b. HOUR	
ANGELA KARIOTIS				Oct 8 1980		0830 M	
3 SEX	4 RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Female	White	MONTH DAY YEAR		79		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Greece	Greece			Carroll County MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Finksburg	1504 Seminole Lane			housewife		-	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE	13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.	Carroll	Finksburg		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1504 Seminole Lane	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST				FIRST MIDDLE LAST			
George Zeppos				Irene Phissos			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			
No		232-07-4555D		Mary N. Coroneos, 1504 Seminole Lane Finksburg, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Sepsis</u>							
DUE TO, OR AS A CONSEQUENCE OF (b) _____							
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
<u>Uremia</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>79</u> , to <u>Oct 8</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>Oct 6</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
<u>John S. Harshey, M.D.</u>				10/8/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
JOHN S. HARSHEY		8 Anchor St. Westminster, Md. 21157					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		10-11-80		Greek Orthodox Cemetery		Baltimore County Baltimore MD.	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Nicholas T. Matthews, 3021 Eastern Avenue Baltimore, Md.				OCT 10 1980		<u>[Signature]</u>	



CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Grover Samuel Korrell			2a. DATE OF DEATH Month 10 Day 2 Year 80			2b. HOUR P 6:25 M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH 10-16-1900		6. AGE (In years lost birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll				
10. CITY OR TOWN OF DEATH Sykesville, Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield Hospital Center			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farm laborer			12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. USUAL RESIDENCE (Where deceased lived at admission) STATE Maryland			13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Route #7	
14. FATHER'S NAME First Middle Last John P. Korrell				15. MOTHER'S MAIDEN NAME First Middle Last Cornelia Burrier						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. 214-10-4565		17. INFORMANT Address Records, Springfield Hospital Center, Sykesville, Maryland 21784					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CUA, Organic brain syndrome years 436- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ASUD. Lt. hemiparesis (previous stroke). years DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis. years									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS CONTRIBUTING <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from July 21, 1965 , to Oct. 2, 1980 , that (I) (we) last saw the deceased alive on 10-02-1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE STRAHIL D. Nacev, M.D.			22c. DATE SIGNED 10/2.80 6:25 pm			22d. PHYSICIAN'S NAME (Type) STRAHIL D. Nacev, M.D.				
22e. ADDRESS Springfield Hospital Center,										
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE Oct. 8, 1980			23c. NAME OF CEMETERY OR CREMATORY Rocky Springs Cemetery				
23d. ADDRESS Frederick, Maryland			23e. CITY Frederick			23f. COUNTY Frederick			23g. STATE Md.	
24. FUNERAL DIRECTOR Wm. H. Keene & Basford Funeral Home			25a. REC'D BY REGISTRAR DATE OCT 9 1980			25b. REGISTRAR'S SIGNATURE Robert J. Keene				
100 East Church Street, Frederick, Maryland										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Clarence W. Lawrence			2a. DATE OF DEATH Month 10 Day 3 Year 80			2b. HOUR 7:38 P.M.						
3. SEX Male		4. RACE White		5. DATE OF BIRTH 6-21-05		6. AGE (In years last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll						
10. CITY OR TOWN OF DEATH Sykesville, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield Hospital Ctr.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Salesman			12b. KIND OF BUSINESS OR INDUSTRY Sales				
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Mt. Savage		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First Middle Last T. J. Lawrence			15. MOTHER'S MAIDEN NAME First Middle Last Savanah Lawrence									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 215-64-1848		17. INFORMANT Address Records, Springfield Hospital Center,							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent Bleeding Carcinoid Tumor 1889 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bladder Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) Senility - Arteriosclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months Months Years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS OR CONTRIBUTING <input type="checkbox"/> UNFLYING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 4-30 , 19 81 , to 10-3 , 19 80 , that (I) (we) last saw the deceased alive on 10-3 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE E. Robinson M.D.						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 10/3/80			
22d. PHYSICIAN'S NAME (Type) E. Robinson, M.D.						22e. ADDRESS Springfield Hospital Center,						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 10-6-80		23c. NAME OF CEMETERY OR CREMATOR Springfield Cemetery		23d. LOCATION (City or Town) (County) (State) Sykesville, Md. Carroll Md.					
24. FUNERAL DIRECTOR Harold E. ...						25a. REC'D BY REGISTRAR 10/8 1980		25b. REGISTRAR'S SIGNATURE ...				



CERTIFICATE OF DEATH

Place

Residence

Date

Age

Sex

Married

Religion

Education

Occupation

Cause of Death

Medical History

Signature

Witness

Date

RECEIVED

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

26029

1. DECEASED NAME (TYPE OR PRINT) **Charles James Lloyd, III**

2a. DATE OF DEATH ☒ KNOWN ☐ ESTIMATED **10 29 1980**

2b. HOUR **3:45 P.M.**

3. SEX **Male**

4. RACE **Black**

5. DATE OF BIRTH **10 23 57**

6. AGE (IN YEARS LAST BIRTHDAY) **23 YRS.**

7. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

7c. DATE PRONOUNCED DEAD **11 2 1980**

7d. HOUR **3:45 P.M.**

8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) **MD**

9. CITIZEN OF WHAT COUNTRY? **USA**

10. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

11. BALTIMORE CITY OR COUNTY OF DEATH **Carroll County**

12. CITY OR TOWN OF DEATH **Henryton**

13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) **3/4 mile N. of Henryton Park Road**

14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

15. KIND OF BUSINESS OR INDUSTRY

16. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

17a. STATE **MD**

17b. COUNTY **Carroll**

17c. CITY OR TOWN **Baltimore**

17d. INSIDE CITY LIMITS? YES ☒ NO ☐

17e. STREET ADDRESS **912 Bunche Road**

18. FATHER'S NAME FIRST MIDDLE LAST **Charles James Lloyd Jr.**

19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST **Jeanette Walker**

20a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) **No**

20b. SOCIAL SECURITY NO. **212-78-2915**

20c. INFORMANT ADDRESS **Charles J. Lloyd Jr. 912 Bunche Rd.**

21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Acute secobarbital intoxication**

DUETO, OR AS A CONSEQUENCE OF

(b)

DUETO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

22. DATE OF OPERATION

23. CONDITION FOR WHICH OPERATION WAS PERFORMED?

24. AUTOPSY? YES ☒ NO ☐

25. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

26. TIME OF INJURY HOUR A.M. MONTH DAY YEAR **? P.M. 11 ? 1980**

27. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) **Ingestion of drugs**

28. INJURY OCCURRED WHILE ☐ NOT WHILE ☒ AT WORK ☐ AT WORK

29. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) **Wooded area**

30. LOCATION STREET CITY OR TOWN COUNTY STATE **Henryton Pk, Rd Carroll Co, Md.**

31. I certify that I took charge of the remains described above, held on ☒ Autopsy ☐ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒

32. ACTUAL SIGNATURE **Margarita A. Korell** TITLE (SPECIFY) **Assistant** MEDICAL EXAMINER DATE SIGNED **11-3-80**

33. EXAMINER'S NAME (TYPE OR PRINT) **Margarita A. Korell, M.D.** ADDRESS **111 Penn Street**

34. BURIAL, CREMATION, REMOVAL (SPECIFY) **Burial** 35. DATE **11/6/80** 36. NAME OF CEMETERY OR CREMATORY **King Memorial Pk.** 37. LOCATION CITY OR TOWN COUNTY STATE **Baltimore Co. MD**

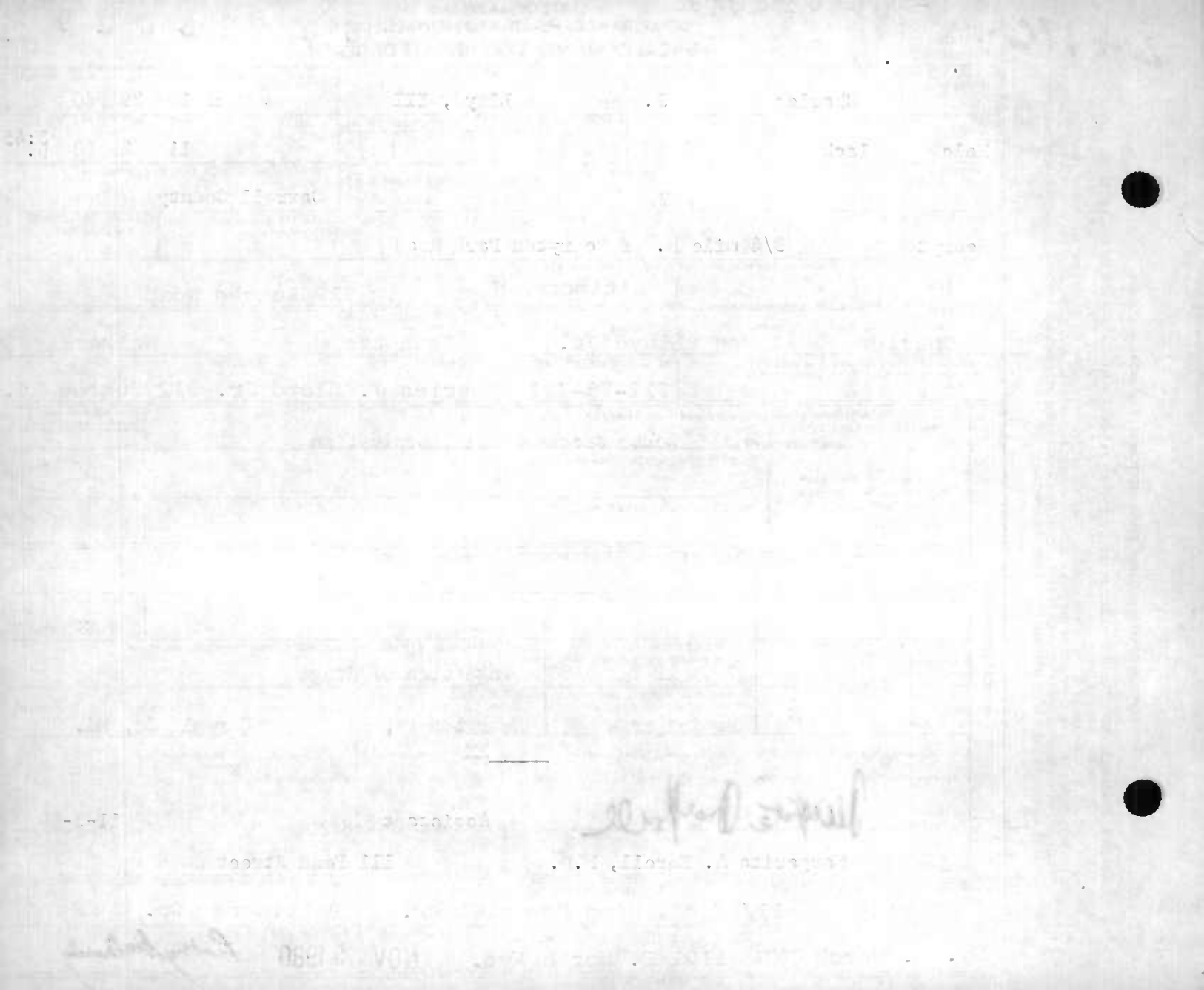
38. FUNERAL DIRECTOR NAME ADDRESS **Wm. C. March F/H 1101 E. North Ave.** 39. DATE REC'D. BY REGISTRAR **NOV 5 1980** 40. REGISTRAR'S SIGNATURE **Robert A. Kelly**

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 7/76





STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

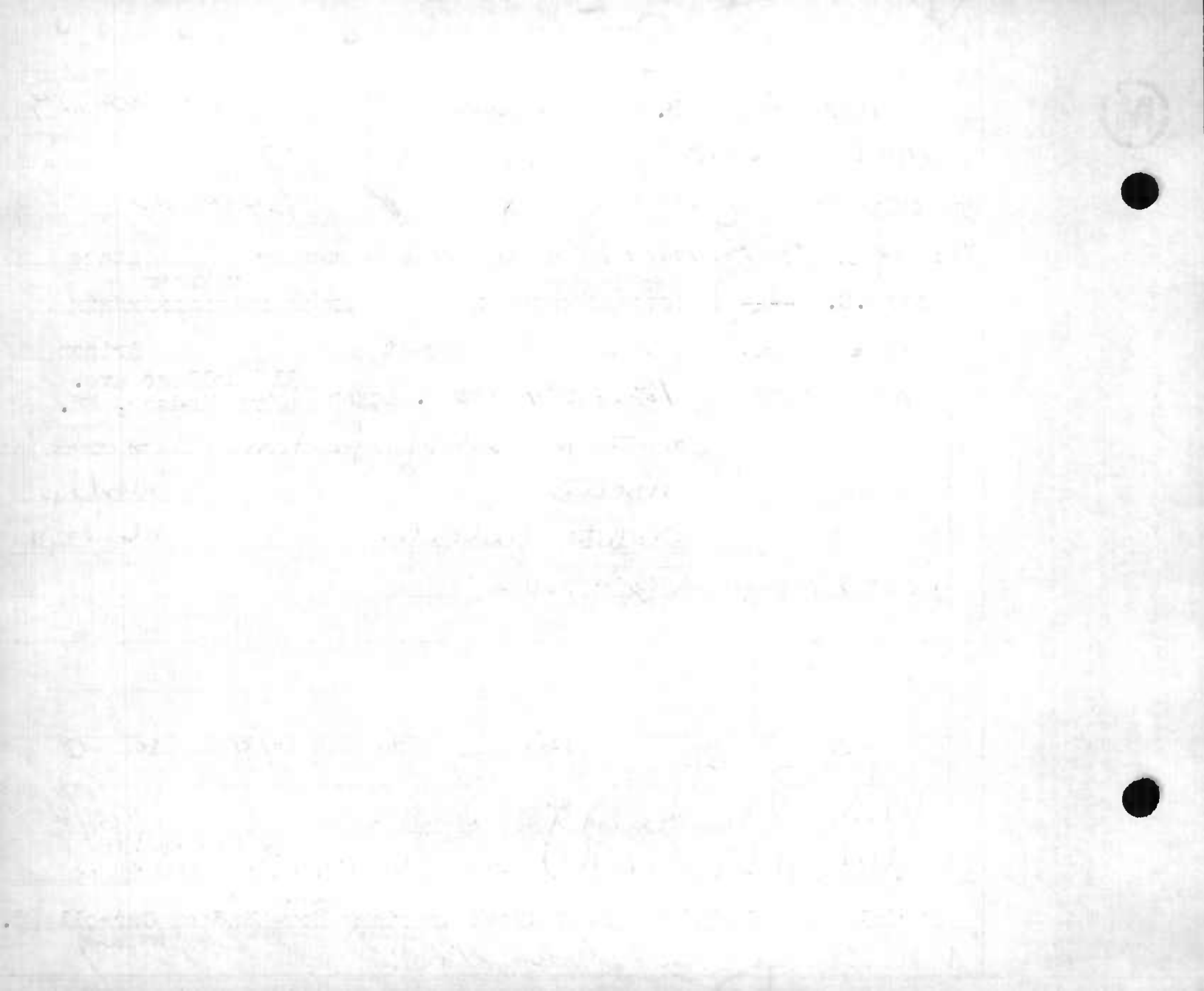
1 DECEASED NAME (TYPE OR PRINT) Robert H. Logan			2a. DATE OF DEATH MONTH DAY YEAR 10 31 80			2b. HOUR 12⁴⁵ P.M.			
3 SEX male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 11 11 31		6 AGE (IN YEARS LAST BIRTHDAY) 48 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.			
10 CITY OR TOWN OF DEATH Mt. Airy		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pleasant View Hosp. Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) manager		12b. KIND OF BUSINESS OR INDUSTRY store	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD D.C.		13b. COUNTY Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 315 College Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST Hays K. Logan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Garnet Arison		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 169-24 9036		17. INFORMANT ADDRESS 315 College Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute myocardial infarction 2500 CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. (b) Ascend (c) Diabetes Mellitus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH seconds about 245 about 3425		PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ① CVT ② Hypertension ③ Atherosclerosis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 12/31 , 19 76 , to 10/31 , 19 80 , that (1) (we) last saw the deceased alive on 10/23 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Melvin Kordon M.D.		DEGREE MELVIN KORDON M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/31/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Melvin Kordon M.D.		22e. ADDRESS 2000 Century Plaza Columbia Md. 21044							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/3/80		23c. NAME OF CEMETERY OR CREMATORY Pipe Creek Cemetery		23d. LOCATION near New Windsor Carroll Md. COUNTY STATE			
24. FUNERAL DIRECTOR NAME D. D. Lutzler		ADDRESS New Windsor, Md.		25a. DATE REC'D. BY REGISTRAR NOV 3 1980		25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows only injury, or other traumatic event, the medical examiner must be notified of same.

BP



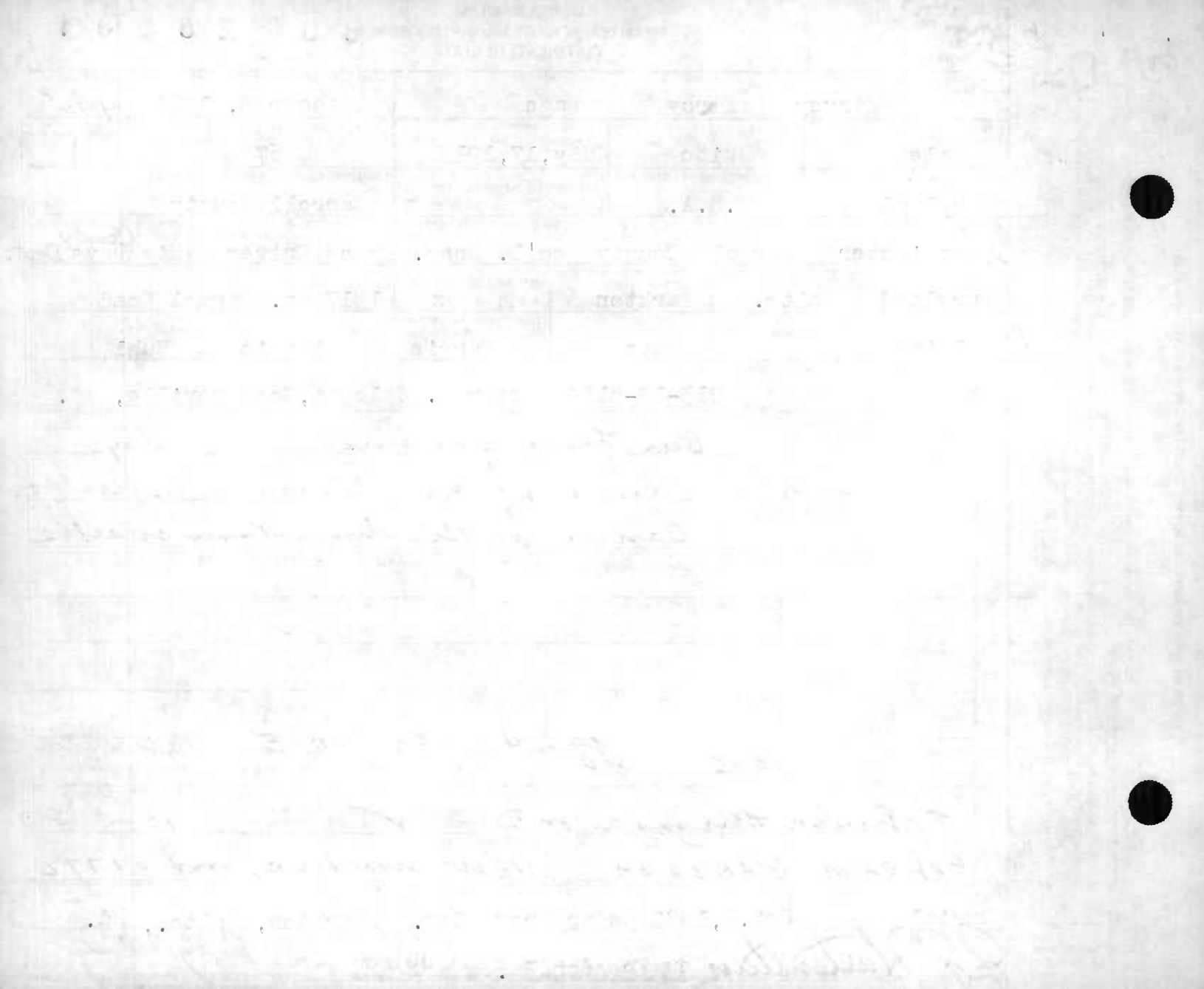
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	0	2	6	0	3	1	
1. FOR STATE REGISTRAR										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Harvey Leroy Mays										2a. DATE OF DEATH MONTH DAY YEAR October 5, 1980				2b. HOUR 4:35 P.M.			
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR July, 17, 1913			6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.			
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.								
10. CITY OR TOWN OF DEATH Westminster			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County Gen'l. Hosp.							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver			12b. KIND OF BUSINESS OR INDUSTRY Highways Dept.				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland										13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1317 Mt. Carmel Road			
14. FATHER'S NAME FIRST MIDDLE LAST Blaine Mays					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Lossie Ruhl												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ***** 213-12-8189					17. INFORMANT ADDRESS Betty P. Calcutt, Cockeysville, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bad Liver failure</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cancer of the liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cancer of the lung - Primary</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>weeks</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>9-24</u> 19 <u>80</u> , to <u>10-5</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>10-5</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Ephraim Barzaga M.D.										DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-5-80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EPHRAIM BARZAGA										22e. ADDRESS NEW WINDSOR, Md. 21774							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE Oct. 8, 1980		23c. NAME OF CEMETERY OR CREMATORY Cedar Grove Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Parkton, Balto. Md.							
24. FUNERAL DIRECTOR NAME J. A. Wartenstein										ADDRESS New Freedom, Pa.		25a. DATE REC'D. BY REGISTRAR OCT 8 1980		25b. REGISTRAR'S SIGNATURE [Signature]			



Item 21d G550 12/15/80 dad

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

2 6 0 3 2

1- FOR
STATE
REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Janet			MIDDLE Marie			LAST McConville			2b. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10 28 19 80			2b. HOUR 5:05				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 26 18		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 10 28 19 80			2d. HOUR P				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.							
10. CITY OR TOWN OF DEATH Sykesville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Springfield Hospital Center								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housecleaning				12b. KIND OF BUSINESS OR INDUSTRY Nursing			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												Home & Hospital							
13a. STATE Maryland		13b. COUNTY Howard Co.		13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4412 Dorado Drive											
14. FATHER'S NAME FIRST MIDDLE LAST Augustino Martinoli						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eletta Satti													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 217-05-6812		17. INFORMANT ADDRESS Helen J. Fleck 4412 Dorado Drive													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 9530 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Hanging DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR P.M. 10 28 19 80				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject hanged self											
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Hospital				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Sykesville, Carroll, Md.											
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <i>Virginia L. Dolan</i>				M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 10/29/80							
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn Street															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10/31/80		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.				23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Md.									
24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home 4107 Wilkens Ave.												25a. DATE REC'D. BY REGISTRAR OCT 31 1980		25b. REGISTRAR'S SIGNATURE <i>History McCreedy</i>					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, IT SHOULD BE EXECUTED WITHIN 72 HOURS. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE FUNERAL DIRECTOR. GIVE PAGE 5 TO THE REGISTRAR. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/76
(VR A 15 (4))

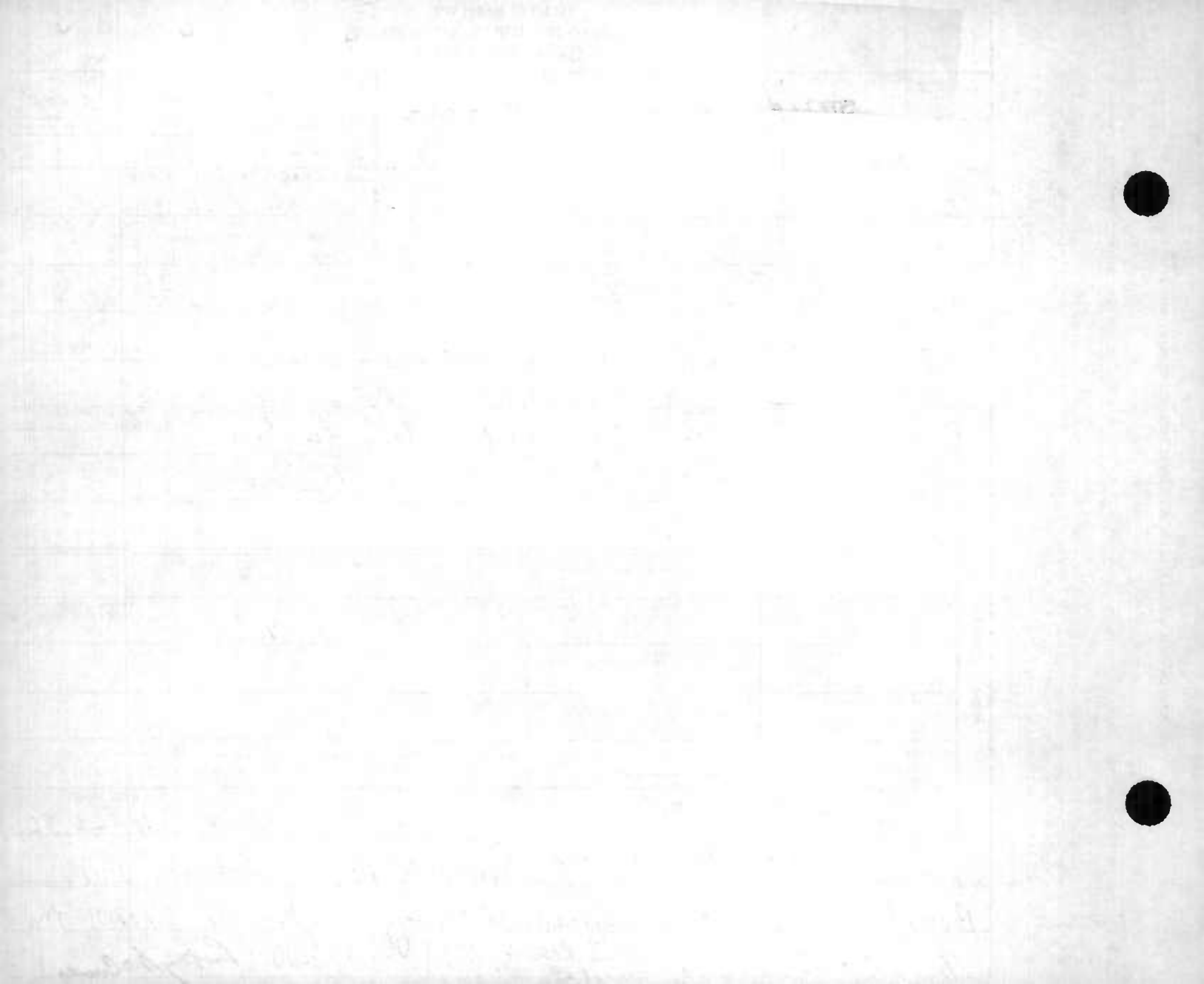
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST STELLA NORA MILLER MEAGER			2a. DATE OF DEATH MONTH DAY YEAR 10 25 80		2b. HOUR 5.50 P.M.					
3. SEX Female		4. RACE CAU		5. DATE OF BIRTH MONTH DAY YEAR 12 2 90		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENN		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.				
10. CITY OR TOWN OF DEATH SYKESVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SPRINGFIELD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY NIA		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.			13b. COUNTY ALLEGHANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 909 BRADDOCK RD.	
14. FATHER'S NAME FIRST MIDDLE LAST ABE NMI MEAGER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY NMI MEAGER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 211-12-8140		17. INFORMANT ADDRESS SPRINGFIELD HOSPITAL CENTER						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory failure 4149 DUE TO, OR AS A CONSEQUENCE OF (b) Ischemic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE E. SENANAYAKE				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 10-25-80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. SENANAYAKE, MD.				22e. ADDRESS Springfield Hospital Sykesville, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-28-80		23c. NAME OF CEMETERY OR CREMATORY Springfield Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll Md.				
24. FUNERAL DIRECTOR NAME ADDRESS Haight Funeral Home Sykesville, Md.				25a. FILED BY REGISTRAR OCT 30 1980		25b. REGISTRAR'S SIGNATURE Houghton				

MEDICAL CERTIFICATION



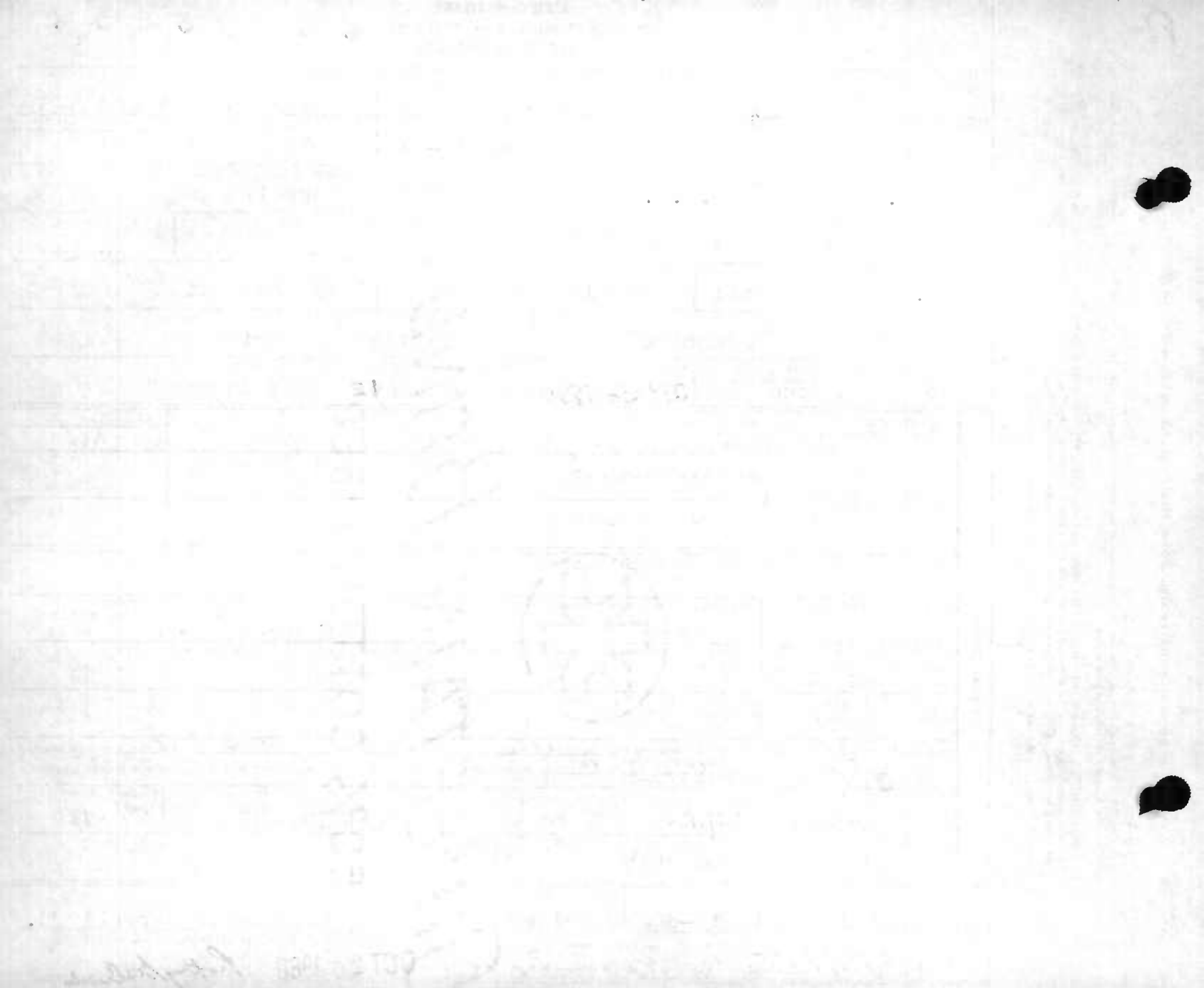
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO. 26034	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Elizabeth G Miller						2a. DATE OF DEATH MONTH DAY YEAR October 14 1980		2b. HOUR 845 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 22-07		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.					
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 75 West Main Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY County			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 75 West Main			
14. FATHER'S NAME FIRST MIDDLE LAST Frank Grumbine				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie Friss							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT ADDRESS Carol Caple Westminister					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crown thrombosis</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 10/6, 19 64, to 10/14, 19 80, that (I) (we) last saw the deceased alive on 10/14, 19 80, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Julius Chepko M.D.						DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/15/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Julius Chepko M.D.						22e. ADDRESS 856 W. Green St Westminster, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10 17-80		23c. NAME OF CEMETERY OR CREMATORY Kriders		23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll Md.				
24. FUNERAL DIRECTOR NAME Robert Kyle Pruthi Jr.						ADDRESS Westminster, Md.		25a. DATE REC'D. BY REGISTRAR OCT 23 1980		25b. REGISTRAR'S SIGNATURE [Signature]	



1 - FOR
STATE
REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST Gloria Ann ORLANDO			2a. DATE OF DEATH MONTH DAY YEAR 10 13 80			2b. HOUR 3:30 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 11 40		6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD	
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6505 Bonnie Brae Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher	
12b. KIND OF BUSINESS OR INDUSTRY School							
13a. STATE Md. 13b. COUNTY CARROLL 13c. CITY OR TOWN Sykesville 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 6505 Bonnie Brae Rd.							
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Knight				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JEAN Hampton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 317 38 3935		17. INFORMANT ADDRESS Frank P. Orlando Sykesville Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Breast Carcinoma 6 mos DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from April 1980, to October 1980, that (I) (we) last saw the deceased alive on Oct 10 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Allen G. Meek				DEGREE MD		22c. DATE SIGNED 10/14/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALLEN G. MEEK				22e. ADDRESS Johns Hopkins Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-17-80		23c. NAME OF CEMETERY OR CREMATORY Springfield Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville CARROLL Md.	
24. FUNERAL DIRECTOR NAME Harry W. Haight				ADDRESS Sykesville, Md.		25a. DATE REC'D. BY REGISTRAR OCT 20 1980	
				25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1- FOR
STATE
REGISTRAR

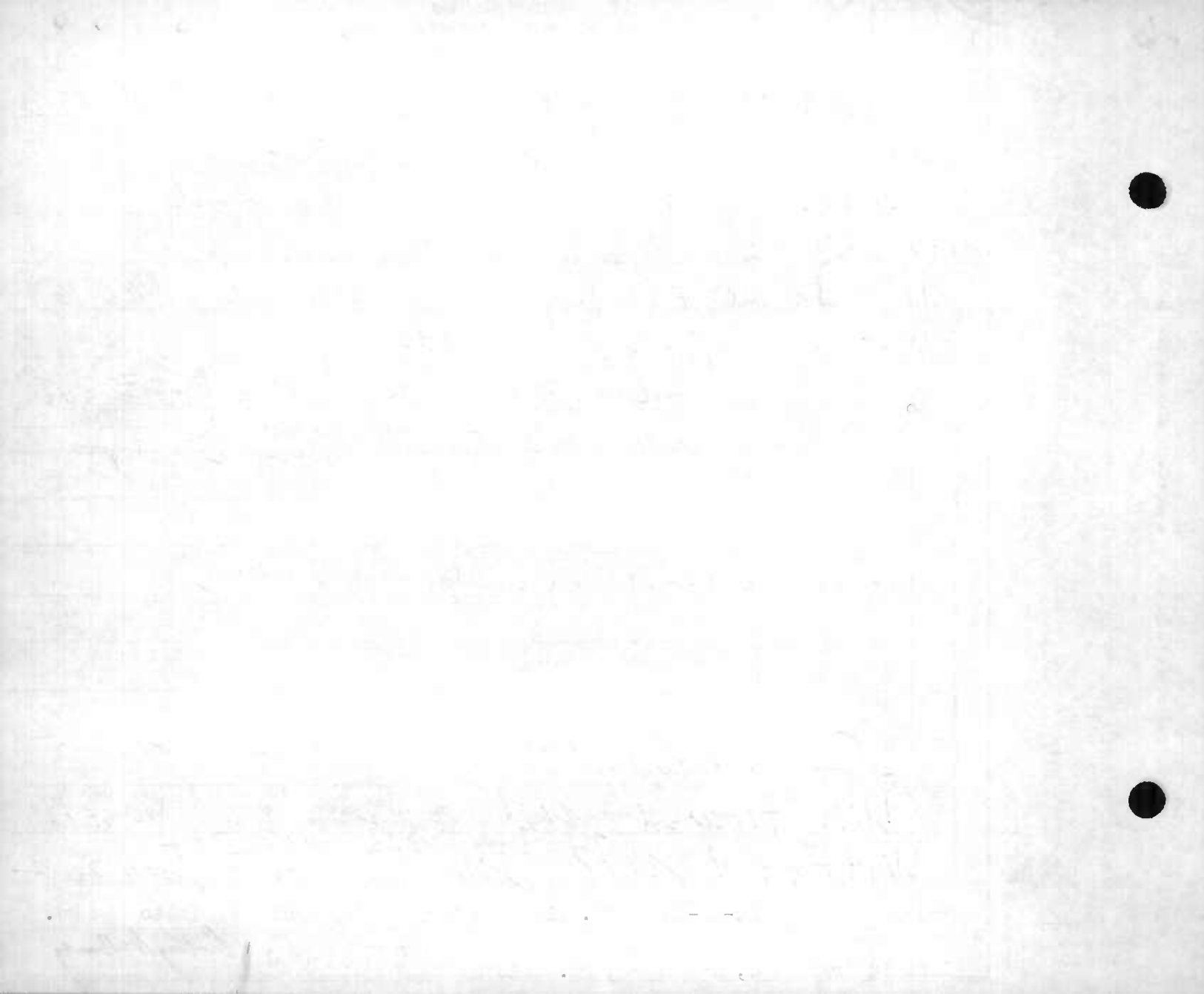
1. DECEASED NAME (TYPE OR PRINT) <u>John M PALMER</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>Oct 25-1980</u>			2b. HOUR <u>535pm</u>		
3. SEX <u>Male</u>			4. RACE <u>White</u>			5. DATE OF BIRTH MONTH DAY YEAR <u>12-20-07</u>		
6. AGE (IN YEARS LAST BIRTHDAY) <u>72</u> YRS			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Carrroll Co Md</u>			9b. CITIZEN OF WHAT COUNTRY? <u>USA</u>			9. BALTIMORE CITY OR COUNTY OF DEATH <u>Carrroll</u> MD.		
10. CITY OR TOWN OF DEATH <u>MANCHESTER</u>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Long View Nursing Home</u>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Book Keeper</u>		
12b. KIND OF BUSINESS OR INDUSTRY			13a. STATE <u>Md</u>			13b. COUNTY <u>Carrroll</u>		
13c. CITY OR TOWN <u>Frederick</u>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS <u>2551 Baltimore Blvd</u>		
14. FATHER'S NAME FIRST MIDDLE LAST <u>Watson</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Ada Wilhelms</u>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>		
16b. SOCIAL SECURITY NO. <u>21610-3057</u>			17. INFORMANT <u>Mrs Lillian Palmer</u> ADDRESS <u>2104P</u>			17. ADDRESS <u>2551 Baltimore Blvd - Frederick Md</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 4292								
DUE TO, OR AS A CONSEQUENCE OF (b) _____								
DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Progressive Cerebral Vascular Insufficiency</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			22a. I certify that (I) (this hospital) attended the deceased from <u>10/11</u> 19 <u>80</u> to <u>10/25</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>10/24/80</u> 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE <u>W H Foward MD</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22c. DATE SIGNED <u>10/25/80</u>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>W H Foward MD</u>			22e. ADDRESS <u>3223 Main St</u>		
22f. ADDRESS <u>MANCHESTER MD 21102</u>			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>10-29-80</u>		
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>			23d. LOCATION CITY OR TOWN <u>Upperco</u> COUNTY <u>Balto</u> STATE <u>Md</u>			24. FUNERAL DIRECTOR NAME <u>Eline Funeral Home, Hampstead, Md. 21074</u> ADDRESS		
25a. DATE REC'D. BY REGISTRAR <u>OCT 31 1980</u>			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			25c. REGISTRAR'S NAME		

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



BP

DHMH-16 25M
(VRA 15, 4) 1/79

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 6 0 3 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>James Howard Peltzer Sr.</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>10-30-80</i>			2b. HOUR <i>00 50 AM</i>		
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Nov. 21 1899</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>80</i>			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	9b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll County</i> MD.				
11. CITY OR TOWN OF DEATH <i>Westminster</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Carroll County General Hosp.</i>			12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Salvage</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Hardware</i>	
13a. STATE <i>Md.</i>	13b. COUNTY <i>Balto.</i>	13c. CITY OR TOWN <i>Reisterstown</i>	14. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13. STREET ADDRESS <i>19000 Emory Road</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>John Harry Peltzer</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Janie Pauline Osborn</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>213-01-5580</i>			17. INFORMANT ADDRESS <i>19000 Emory Rd. Reisterstown, Md.</i>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ASPIRATION PNEUMONIA</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>20 hours</i>
4360 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebrovascular accident</i>		<i>24 hours</i>
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Upper Gastrointestinal Bleeding</i>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>10-29-1980</i> to <i>10-30-1980</i> , that (I) (we) last saw the deceased alive on <i>10-30-1980</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Chitrachedu Nagananna</i>		DEGREE <i>M.D.</i>	22c. DATE SIGNED <i>10/30/80</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>CHITRACHEDU NAGANNA</i>		22e. ADDRESS <i>174 E. Main St. WESTMINSTER MD 21157</i>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>Nov 1 1980</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Pleasant Grove</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Boring Balto Md.</i>
24. FUNERAL DIRECTOR NAME <i>J. E. Shantz</i>		ADDRESS <i>Manchester, Md.</i>	25a. DATE REC'D. BY REGISTRAR <i>NOV 3 1980</i>
		25b. REGISTRAR'S SIGNATURE <i>Barry McCreedy</i>	



NOV 9 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 6 0 3 8			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Niels Amandus Peterson				2a. DATE OF DEATH MONTH DAY YEAR 10 16 80		2b. HOUR 9 05 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10-18-1894		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD	
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Marine	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Carroll		13c. CITY OR TOWN Westminster	
14. FATHER'S NAME FIRST MIDDLE LAST Niels Peterson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Bjerrehus			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) none		17. INFORMANT ADDRESS Mrs. Peggy Day Westminster, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> <u>4340</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC VASCULAR DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>PARKINSON'S DISEASE, ADVANCED</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/30, 1980</u> to <u>10/16, 1980</u> , that (I) (we) lost saw the deceased alive on <u>10/16, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Vincent Brown Jr MD</u> DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/16/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-19-80		23c. NAME OF CEMETERY OR CREMATORY Westminster		23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll Md.	
24. FUNERAL DIRECTOR <u>Robert Kyle Prutts Jr. Westminster, Md</u> ADDRESS				25a. DATE REC'D. BY REGISTRAR OCT 23 1980		25b. REGISTRAR'S SIGNATURE <u>Barry McQuay</u>	

CERTIFICATE OF DEATH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 212016 0 3 9

1. DECEASED-NAME (Type or print) Alkase Pritenett			2a. DATE OF DEATH Month October Day 19 Year 1980			2b. HOUR 9:05AM					
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH 12-23-19		6. AGE (In years lost birthday) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN 	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll					
10. CITY OR TOWN OF DEATH Sykesville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3435 Reisters town Rd.		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address Springfield Hospital Sykesville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Obstructive Pulmonary Disease 496- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years,	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS OR CONTRIBUTING <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Oct. 17, 1980 , to Oct. 19, 1980 , that (I) (we) last saw the deceased alive on Oct. 19, 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Suhay Ozgun, M.D.						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 10-19-80		
22d. PHYSICIAN'S NAME (Type) SUHA OZGUN						22e. ADDRESS Springfield Hospital, Sykesville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE 10/24/80		23c. NAME OF CEMETERY OR CREMATORY Lounden Pk. Cemetery			23d. LOCATION (City or Town) (County) (State) Balto., Md.			
24. FUNERAL DIRECTOR Leroy O. Dyett/son						25a. REC'D BY REGISTRAR OCT 21 1980			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours.



[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page.]

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M
(VRA 15. 4.) 1/79

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8026040

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) RODGER W. REBERT			2a. DATE OF DEATH MONTH 10 DAY 21 YEAR 1980			2b. HOUR 16 MIN 07					
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH 10 DAY 16 YEAR 1913		6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7. IF UNDER 1 YEAR MONTHS 00 DAYS 00		8. IF UNDER 24 HRS HOURS 00 MIN 00	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.					
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Delivery Man		12b. KIND OF BUSINESS OR INDUSTRY Gas			
13a. STATE Md.						13b. COUNTY Carroll		13c. CITY OR TOWN Manchester		13d. STREET ADDRESS 3309 Locust St.	
14. FATHER'S NAME FIRST Roy MIDDLE R. LAST Rebert				15. MOTHER'S MAIDEN NAME FIRST Chie MIDDLE Shorb LAST Shorb							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. 189-07-1851		17. INFORMANT Mary C. Rebert		ADDRESS 3309 Locust St. Manchester, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TERMINAL CANCER										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 YEARS	
1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) PRIMARY CARCINOMA OF COLON DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 1978 , 19 80 , to 10-21 , 19 80 , that (I) (we) last saw the deceased alive on 10-21 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE H. Nipkow						DEGREE MD			22c. DATE SIGNED 10-21-1980		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HANS NIPKOW						22e. ADDRESS WESTMINSTER, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/24/80		23c. NAME OF CEMETERY OR CREMATORY New Lutheran		23d. LOCATION CITY OR TOWN Manchester, Can. Md. COUNTY Carroll STATE Md.				
24. FUNERAL DIRECTOR NAME H. J. Eckhardt ADDRESS Manchester, Md.						25a. DATE REC'D. BY REGISTRAR OCT 24 1980			25b. REGISTRAR'S SIGNATURE Patricia A. B...		

MEDICAL CERTIFICATION



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BP _____
DHMH - 17
(VR A15 ME (5))
15M7/77

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				6026041		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Mabel F.				2a. DATE KNOWN OF DEATH ESTI- MATED 10 13 1980		2b. DATE PRONOUNCED DEAD 10 13 1980		2c. HOUR 69	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2-25-1900		6. AGE (IN YEARS) LAST BIRTHDAY 80 YRS.		7. CITY OR COUNTY OF DEATH Carroll	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.J.		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Carroll		12. MD	
13. CITY OR TOWN OF DEATH Westminster		14. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 56 Timber Ridge				15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homenaker		16. KIND OF BUSINESS OR INDUSTRY Home	
17. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. STATE Md.		17b. COUNTY Carroll		17c. CITY OR TOWN Westminster		17d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		17e. STREET ADDRESS 56 Timber Ridge	
18. FATHER'S NAME FIRST MIDDLE LAST John M. Dillinger				19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mathilder Fisher				20. ADDRESS Mrs. Mabel May Westminster, Md.	
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		22. SOCIAL SECURITY NO. 216-07-4752		23. INFORMANT Mrs. Mabel May Westminster, Md.		24. ADDRESS Westminster, Md.		25. DATE 10-17-80	
26. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410- Atherosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (b) Complicated by Acute Myocardial Infarct DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 months								27. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).	
28. DATE OF OPERATION		29. CONDITION FOR WHICH OPERATION WAS PERFORMED?				30. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
31. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		32. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		33. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 16 PART 2 OR PART 3)				34. LOCATION CITY OR TOWN COUNTY STATE	
35. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		36. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		37. LOCATION CITY OR TOWN COUNTY STATE				38. I certify that I took charge of the remains described above, field an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
39. ACTUAL SIGNATURE Robert G. Britts Jr.		40. M.D. Deputy		41. MEDICAL EXAMINER		42. DATE SIGNED 14 Oct 80			
43. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		44. DATE 10-17-80		45. NAME OF CEMETERY OR CREMATORY Evergreen Memorial		46. LOCATION CITY OR TOWN COUNTY STATE Finksburg Carroll Md.			
47. FUNERAL DIRECTOR Robert G. Britts Jr.		48. ADDRESS Westminster, Md		49. DATE REC'D. BY REGISTRAR OCT 23 1980		50. REGISTRAR'S SIGNATURE Robert G. Britts Jr.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1. STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 0 2 6 0 4 2		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) VIRGIE B. Jane SHETTLES			2a. DATE OF DEATH MONTH DAY YEAR 10 18 80		2b. HOUR 4:45 M		
3. SEX Female		4. RACE Can.		5. DATE OF BIRTH MONTH DAY YEAR 11 29 03		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Westminster		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.	
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Sewing Factory	
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Elmer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Wantz		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
17. SOCIAL SECURITY NO. 220-16-0587		18. INFORMANT ADDRESS Mrs. Emma Long 30 E. Green St. Westminster					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinoma tosis 179- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Carcinoma of uterus & cervix DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/15 , 19 80 , to 10/18 , 19 80 , that (I) (we) last saw the deceased alive on 10/18 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.							
22b. SIGNATURE John E. Steers		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/18/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John E. Steers		22e. ADDRESS 210 Washington Hts, Westminster Md 21157					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-21-80		23c. NAME OF CEMETERY OR CREMATORY St. John's Leister's		23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll Maryland	
24. FUNERAL DIRECTOR NAME John Fletcher		24b. ADDRESS 254 East Main St. Westminster, Md. 21157		25. DATE REC'D. BY REGISTRAR OCT 22 1980		25b. REGISTRAR'S SIGNATURE [Signature]	

BP

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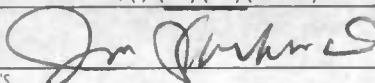

3 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21206 0 4 3
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Charles Eugene Smith			2a. DATE OF DEATH 10 Month 9 Day 80 Year			2b. HOUR 1748 M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH 08-06-00		6. AGE (In years lost birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll				
10. CITY OR TOWN OF DEATH Sykesville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) retired			12b. KIND OF BUSINESS OR INDUSTRY Constellation	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Ma.			13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 104 Schawffer Ave.	
14. FATHER'S NAME First Middle Last John Smith			15. MOTHER'S MAIDEN NAME First Middle Last Sally Strosberg							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO. 217-28-1256		17. INFORMANT Address Hospital chart, Springfield Hospital Center					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular disease 496- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) chronic obstructive Pulmonary disease DUE TO, OR AS A CONSEQUENCE OF (c) acute Pneumonia									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS OR CONTRIBUTING <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 8-21- , 19 80 , to 10-9- , 19 80 , that (I) (we) last saw the deceased alive on 10-9- , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE 						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-9-80		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 10-13-80		23c. NAME OF CEMETERY OR CREMATORY Logist Grove			23d. LOCATION (City or Town) (County) (State) mt Airy Frederick Md		
24. FUNERAL DIRECTOR Robert E. B. [illegible]						25a. REC'D BY REGISTRAR DATE OCT 20 1980		25b. REGISTRAR'S SIGNATURE 		

STATE OF TEXAS
COUNTY OF DALLAS

Declarant

Witness

Notary

07-07-00

10-10-00

10-10-00

Witness

Declarant

Declarant

Witness

Declarant

Witness

Declarant

Declarant

Witness

Declarant

07-07-00

10-10-00

Declarant

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Witness

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Witness

Declarant

Witness

Declarant

Witness

07-07-00

10-10-00

10-10-00

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Pearl Ethel Snyder			2a DATE OF DEATH MONTH DAY YEAR 10-4-1980		2b HOUR 10 45 P M		
3 Sex Female,		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 7 17 08		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b CITIZEN OF WHAT COUNTRY? U.S. Citizen		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH CARROLL CO. MD	
10 CITY OR TOWN OF DEATH Sylkesville		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sylkesville Elder Care Center		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEAMSTRESS		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE md.				13b COUNTY CARROLL		13c CITY OR TOWN Westminster	
14 FATHER'S NAME FIRST MIDDLE LAST Jonathan C. Snyder				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Bertha Morse			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-16-5744		17 INFORMANT ADDRESS Shelly Feldman SOCIAL Worker CCG			
18 CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Metastasis 1844 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Vulva Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from October 4, 1980 to October 4, 1980 , that (I) (we) last saw the deceased alive on October 4, 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Jose L. Chapultepec, M.D.				22c DATE SIGNED 10/4/80		22d ADDRESS 3642 Barnett Ave, Sylkesville, Md.	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/7/80		23c NAME OF CEMETERY OR CREMATORY Damascus Church Cem.		23d LOCATION CITY OR TOWN COUNTY STATE St. Rt. 928, Fulton Co. Penna.	
24 FUNERAL DIRECTOR NAME ADDRESS H. Wayne George 202 Greene St. Cumberland, Md.				25a DATE REC'D. BY REGISTRAR OCT 14 1980		25b REGISTRAR'S SIGNATURE [Signature]	

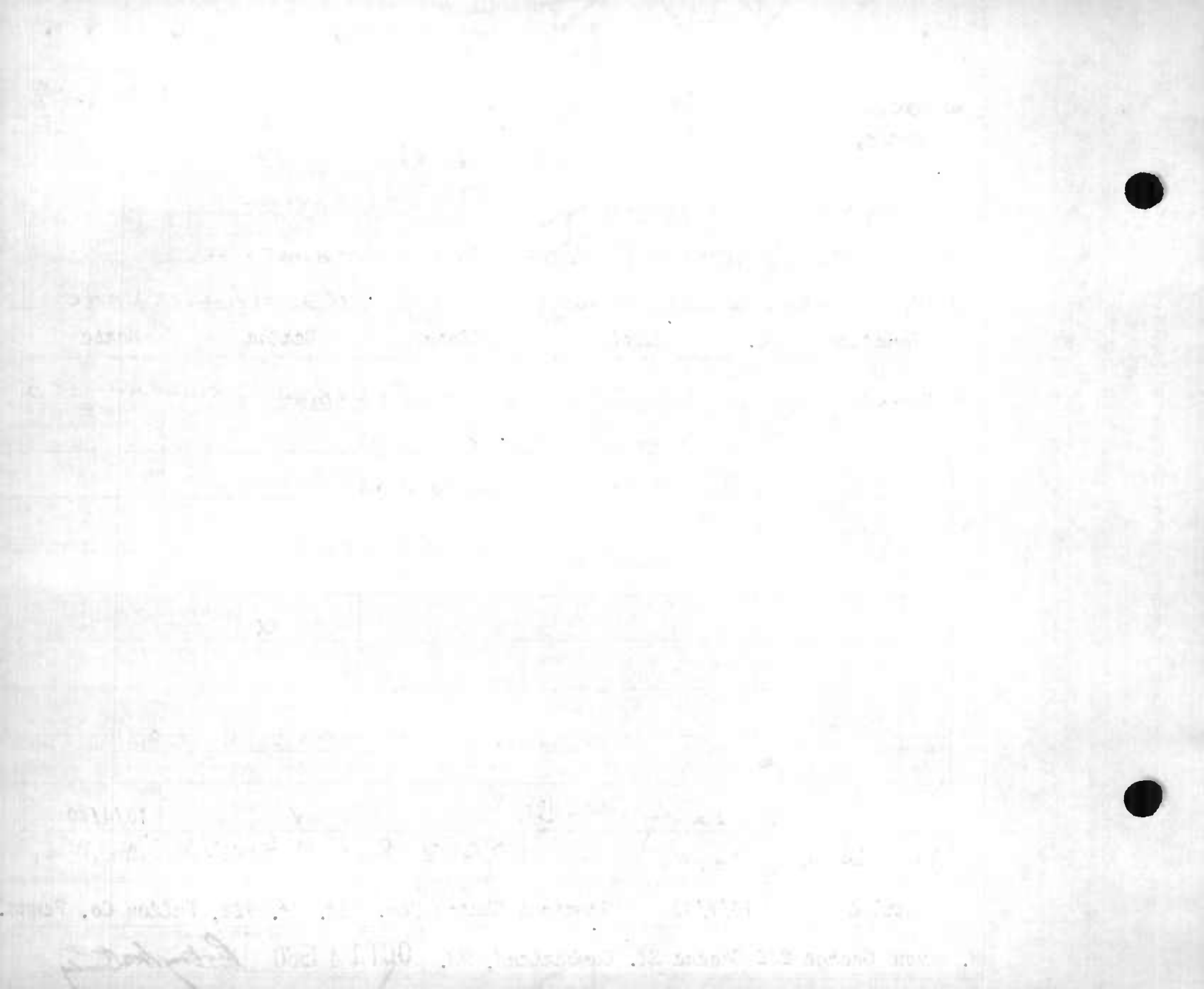
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 6 0 4 5

1 - FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Carl Duncan Standiford</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>10 04 80</i>	
3 SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>04 22 16</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Sharon, Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>64</i> YRS.	8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
10. CITY OR TOWN OF DEATH <i>Sykesville</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>3 Roosevelt Road, Sykesville</i>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll County</i> MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>	13b. COUNTY <i>Carroll</i>	13c. CITY OR TOWN <i>Sykesville</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>XX</i>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Frank E. Standiford</i>	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Ireland</i>	13e. STREET ADDRESS <i>3 Roosevelt Road, 21784</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>	16b. SOCIAL SECURITY NO. <i>215-09-7171</i>	17. INFORMANT <i>Emma M. Byrd Standiford, 3 Roosevelt Road, Sykesville, Md. 21784</i>	
18. CAUSE OF DEATH (Enter only one cause per line, and only one line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma</i> <i>1991</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>5/20/64</i> 19 <i>80</i> , to <i>10-3-</i> 19 <i>80</i> , that (I) (we) last saw the deceased on <i>9-9-</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and could not) view the body after death.			
22b. SIGNATURE <i>Rafael Pere 2-Mera</i>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>10-6-80</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>KAPAELE PERE 2-MERA</i>	22e. ADDRESS <i>5400 OLD COURT ROAD</i>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>10/08/80</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith Cem.</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Baltimore, Md. 21206</i>
24. FUNERAL DIRECTOR <i>Loring Byers Funeral Directors P.A.</i> <i>8728 Liberty Road, Randallstown, Md. 21133</i>		25a. DATE REC'D. BY REGISTRAR <i>OCT 7 1980</i>	25b. REGISTRAR'S SIGNATURE <i>Patricia Kennedy</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1000 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1- FOR STATE REGISTRAR		8 0 2 6 0 4 6				REG. NO.					
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR MIN	
DONALD M.		THOMPSON						10 18 80		11 55 P.M.	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Male		White		8 4 1915		65 YRS.					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				Carroll Co. MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Westminster		Carroll County Gen'l Hospital						Painter		St. Joseph Hosp.	
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS			
Md.		Carroll		Westminster				2550 Albert Rill Road			
14 FATHER'S NAME FIRST MIDDLE LAST				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
David Thompson				Mollie Tawney							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS					
yes WW2				220-07-7024		Mr. Donald E. Thompson, Westminster, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>myocardial infarction</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
2500 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) <u>diabetes mellitus</u>											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>10/18</u> 19 <u>80</u> , to <u>10/18</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>10/18</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				22b. SIGNATURE DEGREE <u>MD</u>				22c. DATE SIGNED <u>10/19/80</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				10-21-80		Evergreen Mem. Gardens		Finksburg Carroll Md.			
24 FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Eline Funeral Home Hampstead, Md. 21071								OCT 22 1980		<u>Robert M. Brady</u>	



[Faint, mostly illegible text and markings across the page, possibly bleed-through from the reverse side.]

[Handwritten signature or initials.]

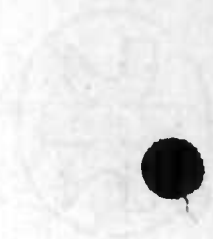
OCT 2 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	0	2	6	0	4	7	
1- FOR STATE REGISTRAR										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Doris Mildred Van Cleaf										2a. DATE OF DEATH MONTH DAY YEAR 10-10-80				2b. HOUR 6:30 PM			
3. SEX female			4. RACE white			5. DATE OF BIRTH MONTH DAY YEAR 4 13 10			6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Conn.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.								
10. CITY OR TOWN OF DEATH Westminster			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll CO. Gen. Hosp.							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) employee			12b. KIND OF BUSINESS OR INDUSTRY Health Dept				
13a. STATE Md			13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 80 Timber Ridge Dr.								
14. FATHER'S NAME FIRST MIDDLE LAST James Carter					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel M. Perry												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 213-09-8035			17. INFORMANT ADDRESS Frances Atkins Eldersburg, Md											
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u> 4912 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Obstructive Pul. Dis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Bronchitis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>ASIA - CVA -</u>																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>10-9</u> , 19 <u>80</u> , to <u>10/10</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>10-9</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>M. J. Sevilla</u>										DEGREE <u>MD</u>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MANUEZ J. Sevilla										22e. ADDRESS 410 C. Malcolm Dr. Westminster							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation				23b. DATE 10/10/80		23c. NAME OF CEMETERY OR CREMATORY Security Pro cess				23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balt. Md							
24. FUNERAL DIRECTOR <u>Edith K. K. K.</u>										ADDRESS Baltimore, Md.		25a. DATE REC'D. BY REGISTRAR OCT 20 1980				25b. REGISTRAR'S SIGNATURE <u>Robert H. B.</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 6 0 4 8

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Chloe B. Waefield				2a. DATE OF DEATH MONTH DAY YEAR 10 - 20 - 80				2b. HOUR 4⁰⁶ P M	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 3 7 '93		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.			
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Westminster Nursing + Conv. Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Store Clerk		12b. KIND OF BUSINESS OR INDUSTRY Grocery	
13a. STATE Maryland				13b. COUNTY Carroll		13c. CITY OR TOWN Mt. Airy		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Browning				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eliza Lightfoot					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 219-20-2511		17. INFORMANT ADDRESS Lindsay L. Browning, Mt. Airy, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic breast carcinoma 1749 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) none									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4/25 , 19 79 , to 10/20 , 19 80 , that (I) (we) last saw the deceased alive on 10/20 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Norman A. Poulsen MD						22c. DATE SIGNED 10/20/80		DEGREE MD	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NORMAN A. POULSEN						22e. ADDRESS 218 WASH. HGTS. MED. CENTER WESTMINSTER MD. 21157			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/22/80		23c. NAME OF CEMETERY OR CREMATORY Pine Grove Ceme.		23d. LOCATION CITY OR TOWN COUNTY STATE Mt. Airy Carroll Md.		25a. DATE REC'D. BY REGISTRAR OCT 23 1980	
24. FUNERAL DIRECTOR NAME ADDRESS Olin L. Molesworth, P.A. Damascus, Md.						25b. REGISTRAR'S SIGNATURE [Signature]			

BP

no
Lindsay B. Browning, M.D., M.P.H.
lightfoot
Maryland Carroll M.D. M.P.H.
x
6 Baker Street
Grocery

Oliver A. Tolson, M.D., M.P.H.
10/22/80 Pine Grove Lane, M.D. M.P.H. Carroll M.D.
10/22/80

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

80 26049

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DONALD G. WARREN		2a. DATE OF DEATH MONTH 10 DAY 18 YEAR 80		2b. HOUR 08 AM	
3 SEX MALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH 6 DAY 3 YEAR 09	
6 BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9 BALTIMORE CITY OR COUNTY OF DEATH CARROLL COUNTY MD.		10 CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 18 Hickory Court	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YRS.) MTA (RETIRED)		12b. KIND OF BUSINESS OR INDUSTRY Transit Co.		13a. STATE MARYLAND	
13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST Carroll MIDDLE E. LAST Warren		15 MOTHER'S MAIDEN NAME FIRST Burde MIDDLE V. LAST Gilbert		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	
16b. SOCIAL SECURITY NO 212072351		17 INFORMANT Mrs. Grace Despeaux		ADDRESS 280 Pinoak Drive, Frederick, MD 21701	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (b) diabetes mellitus DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 2500					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 9/26 19 80 to 9/26 19 80 , that (I) last saw the deceased alive on 9/26 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		22b. DATE SIGNED 10/18/80	
22c. SIGNATURE Park W. Espenschade Jr.		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PARK W. ESPENSCHADE JR.		22e. ADDRESS 218 WASH HIGHTS MED CNTR, WESTMINSTER		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	
23b. DATE 10/21/80		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville Baltimore MD	
24 FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, F.A. ADDRESS 8728 Liberty Rd., Randallstown, MD 21133		25a. DATE REC'D. BY REGISTRAR OCT 21 1980		25b. REGISTRAR'S SIGNATURE Loring Byers	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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10/10/80

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 6 0 5 0			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) Marie Cecilia Watson				2a. DATE OF DEATH MONTH DAY YEAR 10-19-80		2b. HOUR 0133M	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 2-9-1907		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.	
10 CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13b. STREET ADDRESS 4016 Old Wm. Penn Highway	
13a. STATE Pa.		13b. COUNTY Westmoreland		13c. CITY OR TOWN Murrysville			
14 FATHER'S NAME FIRST MIDDLE LAST Stephen Bantle				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Teofila Berjenski			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. none		17 INFORMANT ADDRESS Carol Boxuma Westminster, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiogenic Shock DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 410-						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 hours 14 hours	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10-18-1980 , to 10-19-1980 , that (I) (we) lost saw the deceased alive on 10-19-1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Chitrachedu Naganna DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10/19/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHITRACHEDU NAGANNA MD				22e. ADDRESS 174 E. main st. Westminster MD 21157.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 22, 1980		23c. NAME OF CEMETERY OR CREMATORY Twin Valley Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Delmont Westmoreland Pa.	
24. FUNERAL DIRECTOR NAME Robert Kyle Brith ADDRESS Westminster, Md.				25a. DATE REC'D. BY REGISTRAR OCT 23 1980		25b. REGISTRAR'S SIGNATURE Christy McCondy	

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Oct 25 1980

Oct 25 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 2 6 0 5 1	
CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Marie L. Wheeler</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>10-3-80</i>		2b. HOUR <i>0200</i> M			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1 6 1903</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>77</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll</i> MD.					
10. CITY OR TOWN OF DEATH <i>Westminster</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Carroll County General Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Seamstress</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>-</i>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <i>MD</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>6610 Fairmount Ave. 21215</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Louis Holter</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Florence Horstman</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>213-18-3195</i>		17. INFORMANT ADDRESS <i>Mr. Paul Wheeler 21157</i> <i>2201 Old Washington Rd., Westminster, MD</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspiration pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>CARCINOMATOSIS</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i> <i>1 month</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>9-25-</i> 19 <i>80</i> , to <i>10-3-</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>10-2-</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Chitrachudu Naganna</i>						DEGREE <i>MD</i>		22c. DATE SIGNED <i>10-3-80</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>CHITRACHUDU NAGANNA MD</i>						22e. ADDRESS <i>174 E. Main St. - Westminster MD 21157</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>10/6/80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Woodlawn Baltimore MD</i>					
24. FUNERAL DIRECTOR NAME ADDRESS <i>Loring Byers Funeral Directors, P.A. 8728 Liberty Rd., Randallstown, MD 21133</i>						DATE REC'D. BY REGISTRAR <i>OCT 7 1980</i>		REGISTRAR'S SIGNATURE <i>Loring Byers</i>			

MEDICAL CERTIFICATION

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FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 0 2 6 0 5 2

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HARRY STERLING YINGLING SR.			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 31-1980			2b. HOUR 4:00 A.M.		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 15-1910		6. AGE (IN YEARS LAST BIRTHDAY) 70		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.		
10. CITY OR TOWN OF DEATH Union Bridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 258 Middleburg Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) farmer		12b. KIND OF BUSINESS OR INDUSTRY agriculture	
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Union Bridge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS 258 Middleburg Rd.								
14. FATHER'S NAME FIRST MIDDLE LAST Charles Yingling				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisy Zimmerman				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) none		17. INFORMANT ADDRESS Betty J. Muller Union Bridge, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Atrial Fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4-26-76 4-26-76 4-26-78	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 4-26-76 to Oct 31 , 19 80 , that (I) (we) last saw the deceased alive on Oct 30 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.								
22b. SIGNATURE W. Glenn Speicher MD				DEGREE MD		22c. DATE SIGNED Oct 31-1980		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. GLENN SPEICHER MD WESTMINSTER				22e. ADDRESS 135 EAST MAIN ST				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/3/80		23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Manchester Carroll Md.		
24. FUNERAL DIRECTOR NAME D. D. Harbler				ADDRESS New Windsor, Md.		25a. DATE REC'D. BY REGISTRAR NOV 3 1980		
				25b. REGISTRAR'S SIGNATURE [Signature]				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The certificate is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

